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No. 60554-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and
OVERLAKE HOSPITAL MEDICAL CENTER

and

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2,
d/b/a EVERGREEN HEALTHCARE,

Appellants,

vs.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON

and

SWEDISH HEALTH SERVICES,

Respondents

BRIEF OF RESPONDENT SWEDISH HEALTH SERVICES

DORSEY & WHITNEY LLP
Peter S. Ehrlichman, WSBA #6591
Brian W. Grimm, WSBA #29619

U.S. Bank Centre
1420 Fifth Avenue, Suite 3400
Seattle, Washington 98101
Telephone: (206) 903-8800
Facsimile: (206) 903-8820

Attorneys for Respondent,
Swedish Health Services

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I. INTRODUCTION

Swedish Health Services ("Swedish") plans to build a $7.4 million ambulatory surgery center ("ASC") in Bellevue. Given the rapid population growth on the Eastside in recent years, as well as increasing demand for outpatient surgical procedures, this facility is needed to meet the health care requirements of Eastside residents. Swedish's ASC has been approved by the Washington Department of Health (the "Department"), which determined, following extensive analysis, that East King County has a shortage of outpatient operating rooms ("ORs") and that Swedish's proposed facility satisfies all Certificate of Need ("CN") criteria.

The Department's approval of Swedish's facility is being challenged by Bellevue-based Overlake Hospital and Kirkland-based Evergreen Healthcare (collectively "Petitioners"), which seek to prevent "competition" from Seattle-based Swedish on the Eastside. Petitioners first appealed to the King County Superior Court, where the Department's decision was affirmed by the Honorable Julie A. Spector. Petitioners have now appealed Judge Spector's decision to this Court.

It is undisputed that under the Department's methodology for projecting operating room need within a health services planning area, Swedish's application was properly approved. Therefore, in order to

challenge the Department's decision in this case, Petitioners are left attacking the Department's methodology itself. Petitioners have requested that this Court reject the Department's methodology as flawed and order the Department to adopt a revised methodology which will result in less operating room need projected, and thus fewer operating rooms approved by the Department and available to the public. Petitioners' results-oriented approach would not only deny Eastside residents a much needed new health care facility, but would also harm Washington residents statewide, by severely limiting the number of operating rooms that could be approved in the future.

The Court should deny Petitioners' request. The Department's interpretations of its own regulations are entitled, as a matter of law, to considerable weight and substantial deference. The Department's methodology for projecting operating room need is consistent with both the language of the regulation and the legislative intent underlying it, and is also sound as a matter of public policy. Moreover, the fact that the Department has continued to use this same methodology over the years suggests that it has found it to be an accurate tool for projecting operating room need. Swedish respectfully requests that this Court affirm the Superior Court's decision affirming the Department's approval of

Swedish's application to establish a new ambulatory surgery center in Bellevue.

II. STATEMENT OF ISSUE

Petitioners' appeal presents a single issue: Whether the Department's application of its methodology for projecting operating room need—specifically, the Department's inclusion of surgeries at CN-exempt ASCs (private facilities in physicians' offices) when determining the surgical procedure use rate and exclusion of operating rooms at CN-exempt ASCs when determining existing operating room capacity—is impermissible. If the Court determines that the Department's methodology is permissible, it is undisputed that the Court should affirm the Superior Court's decision affirming the Department's approval of Swedish's application.

III. RECORD ON APPEAL

The record in this appeal has been provided to the Court from the Superior Court Clerk in three, separately-numbered parts. Swedish will use "CP" to refer to the Clerk's Papers. Swedish will use "AR (1st)" to refer to the 2,207-page administrative record which preceded the first judicial review proceeding in King County Superior Court, Case No. 05-2-26241-9 SEA, before the Honorable Douglass A. North. Swedish will use "AR (2d)" to refer to the additional 511-page administrative record

following Judge North's remand to the Department, which preceded the second judicial review proceeding in King County Superior Court, Case No. 06-2-38641-8 SEA, before Judge Spector.

IV. STATEMENT OF THE CASE

A. Overview of the Certificate of Need Regulatory Framework.

In 1979, the Washington Legislature enacted the State Health Planning and Resources Development Act, RCW 70.38 et. seq., creating the Certificate of Need Program (the "Program"). The Program was created to oversee health care planning, and to help further legislative goals in health planning such as providing accessible, quality health care to the residents of Washington, encouraging public participation, and ensuring health care responsiveness to changing health and social needs. See RCW 70.38.015(1). Under the Certificate of Need statutory framework, "[t]he construction, development, or other establishment of a new health care facility" is subject to CN review. RCW 70.38.105(4)(a); WAC 246-310-020(1)(a). "Health care facility" is defined to include "ambulatory surgical facilities" such as the one Swedish seeks to establish in Bellevue. RCW 70.38.025(6); WAC 246-310-010(26); see also WAC 246-310-010(5) (defining "ambulatory surgical facility").

RCW 70.38.105(1) authorizes the Department to administer the Program and RCW 70.38.135(3) gives the Secretary of Health the

authority to promulgate regulations setting up the process for obtaining a CN. The regulations promulgated pursuant to this authority are found at WAC 246-310 et. seq. Prior to opening a new ambulatory surgery center, an entity must submit a CN application to the Program, and undergo the extensive CN review process set forth at WAC 246-310 et. seq.

The Program is responsible for reviewing, and issuing an evaluation of, a CN application. In order to approve an application, the Program must determine that the proposed facility satisfies four basic criteria. See WAC 246-310-210 (Need); 246-310-220 (Financial Feasibility); 246-310-230 (Structure and Process of Care); and 246-310-240 (Cost Containment). For ASCs specifically, the Department has adopted a numeric methodology for projecting future need for additional operating rooms. See WAC 246-310-270 (Ambulatory Surgery). Operating room need is calculated for the specific geographic area, or "secondary health services planning area," in which the proposed ASC will be built. See WAC 246-310-270(2). In this case, the relevant planning area is East King County. See WAC 246-310-270(3).

B. There Is a Shortage of Operating Rooms in East King County.

In recent years, there has been substantial population growth in East King County, as well as increasing demand for outpatient surgery nationwide, both "in absolute terms and as a percent of total surgeries."

AR (1st) 140. "This large growth is the result of: (1) technological advances, e.g., laparscopic surgeries, advanced anesthetic agents and lasers; (2) cost containment efforts to reduce surgical expenses; (3) population growth; and (4) patient preference and convenience. All four of these 'drivers' will continue the shift of surgical procedures to outpatient settings." Id. A leading national study of surgery rates has confirmed an "explosive growth of ambulatory surgery" across the U.S. AR (1st) 200.

Under the Department's methodology, OR need projections are made for the expected third year of operation of the facility, in this case 2009. See WAC 246-310-270(b)(i). The Department has projected a shortage of at least 12 operating rooms in East King County by 2009, including 5.39 outpatient ORs and 6.66 inpatient ORs. AR (2d) 265, 501 (assuming surgical use rate of 82/1,000). Moreover, these projections are based on very conservative assumptions. AR (1st) 2025 (testimony of Department's analyst that 82/1,000 "might be a conservative use rate"). The actual shortage in East King County probably will be at least 23 operating rooms, including 11.34 outpatient ORs and 11.70 inpatient ORs. AR (2d) 264 (assuming surgical use rate of 102/1,000).

C. Swedish Applied For a Certificate of Need To Establish an Ambulatory Surgery Center in Bellevue.

Swedish is one of the largest and most respected health care providers in Washington. It operates three hospitals in Seattle, at its First Hill, Cherry Hill, and Ballard campuses. AR (1st) 133. On November 14, 2002, Swedish applied for a CN to establish a $7.4 million, 5-OR ambulatory surgery center in Bellevue, to better serve its Eastside patients and help meet the need for additional operating rooms in East King County. See generally AR (1st) 128-278 (application).

Swedish's Bellevue ASC will be open to all physicians in the community who have privileges to practice at Swedish, AR (1st) 135, and is expected to serve patients needing, *inter alia*, the following major surgical specialties: orthopedics; gastroenterology; ENT; general surgery; urology; gynecology; and opthamology. AR (1st) 136-37. "Given the increasing emphasis on the provision of medical care in the outpatient setting," as well as patients' increasing "preference to obtain services close to home," Swedish believes "that this ambulatory surgery center will allow for Swedish's medical services to be provided to [its] patients in a more appropriate and cost-effective manner." AR (1st) 135.

D. The Department Approved Swedish's Application; the Department's Health Law Judge Affirmed; the Superior Court Affirmed.

Petitioners have opposed Swedish's efforts to establish an ASC in Bellevue from the very beginning. See, e.g., AR (1st) 360 (Overlake's December 17, 2002 letter requesting affected party status); AR (1st) 364 (Evergreen's January 23, 2003 letter requesting affected party status). Under the original schedule for the facility, Swedish expected to treat its first patient on January 1, 2004 – *four years ago*. AR (1st) 138. Instead, as a result of Petitioners' legal challenges, this case has a complicated, five-year procedural history, beginning with Swedish's November 14, 2002 application for a certificate of need, AR (1st) 128-278, and continuing through the following key events: (1) the Program's May 8, 2003 approval of Swedish's application, AR (1st) 462-77; (2) the Department's May 14, 2003 issuance of Swedish's CN No. 1264, AR (1st) 480-82; (3) Health Law Judge ("HLJ") John F. Kuntz's November 7, 2003 remand to the Department for further review, pursuant to the parties' stipulation, AR (1st) 689-93; (4) the Program's August 25, 2004 approval of Swedish's application, following its additional review, AR (1st) 719-35; (5) the February 16-17, 2005 administrative hearing before HLJ Kuntz; (6) HLJ Kuntz's April 26, 2005 initial final order reversing the Program's determination, AR (1st) 1108-23; (7) HLJ Kuntz's July 8, 2005

amended final order reversing the Program's determination, AR (1st) 1257-73; (8) Judge North's April 19, 2006 order reversing HLJ Kuntz's final order and remanding for further review, AR (2d) 352-54; (9) HLJ Kuntz's November 9, 2006 remand order approving Swedish's application, AR (2d) 491-509; and, finally, (10) Judge Spector's August 23, 2007 order affirming the Department's decision. CP 403.

V. STANDARD OF REVIEW

Judicial review of the Department's decision is governed by the Administrative Procedure Act (the "APA"). See RCW 34.05.570. When reviewing matters within the agency's discretion, the reviewing court "shall limit its function to assuring that the agency has exercised its discretion in accordance with law, and shall not itself undertake to exercise the discretion that the legislature has placed in the agency." RCW 34.05.574(1). The agency's decision is presumed correct and "[t]he burden of demonstrating the invalidity of agency action is on the party asserting invalidity[.]" RCW 34.05.570(1)(a). Moreover, "[t]he court shall grant relief only if it determines that a person seeking relief has been substantially prejudiced by the action complained of." RCW 34.05.570. Therefore, Petitioners must demonstrate that the Department's approval of Swedish's CN application was invalid and that they have been substantially prejudiced by this action.

Where, as here, the interpretation of a regulation is at issue, a reviewing court accords "substantial deference to the agency's interpretation, particularly in regard to the law involving the agency's special knowledge and expertise." Providence Hosp. of Everett v. Dep't of Social & Health Servs., 112 Wn.2d 353, 356, 770 P.2d 1040 (1989). When reviewing an agency's interpretation of a statute it administers, the "construction given a statute by the administering agency is entitled to considerable weight." St. Joseph Hosp. and Health Care Center v. Dep't of Health, 125 Wn.2d 733, 743, 887 P.2d 891 (1995). Significantly, this Court has recognized that "even more deference is owed to an agency's interpretation of its own regulation than to its interpretation of a statute." Clark v. City of Kent, 136 Wn. App. 668, 672, 150 P.3d 161 (2007) (citing Hayes v. Yount, 87 Wn.2d 280, 289, 552 P.2d 1038 (1976) ("[W]hen the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order"); Tuerk v. Dep't of Licensing, 123 Wn.2d 120, 126, 864 P.2d 1382 (1994) ("[T]he power to enforce a regulation implies the concomitant authority to interpret the regulation."); Barrington v. E. Wash. Univ., 41 Wn. App. 259, 263-64, 703 P.2d 1066 (1985) (finding agency's interpretation of its own regulation was entitled to "great weight," and upholding it absent evidence it was unreasonable or arbitrary and capricious)). Under Washington law,

therefore, the Department's interpretation of WAC 246-310-270(9), the methodology it follows to project operating room need, is entitled to considerable weight and substantial deference.

VI. ARGUMENT

A. The Department Has Adopted a Numeric Methodology For Projecting Operating Room Need.

The Department "ordinarily" will not approve a new ASC unless it projects a shortage of available operating rooms in the planning area. See WAC 246-310-270(4). The Department's methodology for projecting operating room need is set forth in WAC 246-310-270(9). There are essentially three steps in the methodology: (1) calculate the "existing capacity" of operating rooms in the planning area; (2) calculate the "future need" for operating room capacity in the planning area; and (3) determine whether the "future need" for operating room capacity is greater than or less than the "existing capacity." See WAC 246-310-270(9). If the "future need" for operating room capacity is greater than the "existing capacity," then new operating rooms are needed in the planning area.

Not all new ASCs require CN approval, however. The regulations specifically carve out an exemption for facilities "in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice." WAC 246-310-010(5). In other

words, if an individual physician or group of physicians wish to have an operating room in their own office, and nobody other than the individual physician or group will be permitted to use the operating room, they do not need to obtain a CN to do so. These closed, private-practice facilities are frequently referred to as "CN-exempt" ASCs.

Petitioners argue that the Department's operating room need methodology is flawed because the "existing capacity" calculation (step 1, above) does not include ORs in CN-exempt ASCs, but the calculation of the surgical use rate, a component of the "future need" calculation (step 2, above), includes surgeries performed at CN-exempt ASCs. Petitioners argue that the Department should either exclude CN-exempt ASCs when determining the surgical use rate, or include CN-exempt ASCs in existing capacity. Thus, Petitioners are unconcerned *which* adjustment the Department makes to its methodology, so long as it makes an adjustment which will negatively impact the net need calculation.

Health Law Judge John F. Kuntz, the Secretary of Health's designee to make the final decision on Swedish's application, specifically considered and rejected Petitioners' argument. In the Department's Final Order, HLJ Kuntz observed that the Department "has historically used this approach" of "includ[ing] the number of surgeries performed at an exempt ambulatory surgery center when determining the surgical procedure use

rate, but exclud[ing] the number of operating rooms in an exempt ambulatory surgical center from the count in existing capacity." AR (2d) 504. HLJ Kuntz held that this approach was correct, based on the language of the regulation and the legislative intent underlying it. AR (2d) 506-8.

B. The Department Properly Excludes CN-Exempt ASCs From "Existing Capacity."

Operating rooms at CN-exempt ASCs must be excluded when calculating "existing capacity" because, by definition, they are not generally available. See WAC 246-310-010(5) (facilities cannot be used by physicians outside the particular private practice). The public policy underlying the CN statute, as stated by the Legislature, is that health planning should "provide *accessible* . . . health facilities," *not* to provide facilities limited only to the patients of a particular physician or group of physicians. RCW 70.38.015(1) ("Declaration of public policy") (emphasis added); see also WAC 246-310-270(4) (contemplating "available" operating rooms).

In addition to not being available to the general surgical population, CN-exempt ASCs are often operated by physicians specializing in certain types of procedures, thus further limiting their availability to, and use by, the general public. This is demonstrated by the list of CN-exempt ASCs in the East King planning area contained in the

record. These include: Bellevue Urology Associates; Eastside Endoscopy Center; Eastside Podiatry ASC; Evergreen Endoscopy Center; Interventional Pain Program; Laboratory for Reproductive Health; Pacific Cataract and Laser Institute; Redmond Foot Care Associates; and Washington Sports Medicine Associates. AR (1st) 850-51. Moreover, the specialty procedures performed in CN-exempt ASCs may be cosmetic, not therapeutic, in nature. This is also demonstrated by the list of ASCs contained in the record. These include: Aesthetic Eye Associates; Dermatology and Cosmetic Surgery of Issaquah; Elan Plastic Surgery; Remington Plastic Surgery; and Sammamish Center for Facial and Plastic Surgery. Id.

As the Department's CN analyst, Randy Huyck, explained at the administrative hearing, "[t]he facilities that are described as exempt facilities, the use of those facilities is limited only to members of those group practices. And very frequently, we see that the use of these facilities is limited to one, sometimes two, different specialties of medicine, such as ENT surgery or oral surgery or something like that. So those operating rooms are not really analogous to a generally available ambulatory surgical center, operating room, where a multitude of various services could be performed by a number of different physicians[.]" AR (1st) 2023. HLJ Kuntz similarly found that "[w]hen calculating the

number of existing facilities in a health service area, it is necessary to exclude from that count the number of operating rooms from . . . exempt facilities[.]" AR (2d) 498.

C. The Department Properly Includes Surgeries at CN-Exempt ASCs in Its Calculation of the Surgical Use Rate.

To determine "future need," the Department projects the number of surgeries that will be performed in the planning area in the facility's third year of operation, "based on the current number of surgeries adjusted for forecasted growth in the population[.]" WAC 246-310-270(9)(b)(i). When calculating the "surgical procedure use rate," i.e., the number of surgeries in the planning area adjusted for population, the Department includes surgeries at CN-exempt ASCs. It does so because, as stated by the Program, the regulation "requires examination of the *total* number of surgeries that is expected to occur in the area." AR (1st) 2046 (emphasis added).

Mr. Huyck explained, at the administrative hearing, that the Department seeks to ensure that all surgeries are accounted for in evaluating whether the needs of the public are being adequately met. All surgeries would not be accounted for if surgeries performed at CN-exempt ASCs were excluded when calculating the surgical procedure use rate. Moreover, "[w]e don't necessarily know the nature of these surgeries in the future. We don't know if they are going to be required by patients

who happen to be patients of the surgeons or doctors that would use these closed-panel facilities." AR (1st) 2048.

The best the Department can do, based on the information available, is project the total number of surgeries expected to be needed. HLJ Kuntz similarly found that "it is necessary to include the surgical volume or number of surgeries that have been performed *both* in . . . surgical centers that are exempt . . . and non-exempt facilities[.]" AR (2d) 498.

D. The Department's Methodology Is Consistent With Legislative Intent And Serves the Department's Stated Policy.

The Department's methodology, described above, is not arbitrary. The calculation of future need and the calculation of existing capacity are, as HLJ Kuntz recognized, "separate concepts." AR (2d) 498. Moreover, the Department has stated that WAC 246-310-270(9) is designed "to insure that the general public has reasonable assurance that there will be enough operating rooms to accommodate the number of surgeries that they will need." AR (1st) 2024. Therefore, as Mr. Huyck testified, the Department interprets and applies WAC 246-310-270(9) in a manner that insures that adequate, publicly-accessible operating room capacity will be available to those in need of surgical care. Thus, there is no inconsistency in counting all surgeries, including those performed in CN-exempt ASCs, when determining the surgical procedure use rate, while not counting

operating rooms located in CN-exempt ASCs when determining total operating room capacity. Simply put, this is the only means of ensuring that there are enough generally-available operating rooms to meet the total surgical need of the public.

Petitioners mistakenly characterize the Department's rationale as "based on an . . . assumption that the capacity for Exempt Surgical Facilities is shrinking[.]" Pet. Br. at 32. The Department's rationale is instead based on its determination that there should be enough generally-available operating rooms to meet the total surgical need of the public. Whether the number of CN-exempt ASCs is growing or shrinking does not affect the number of generally-available operating rooms in the planning area, which is the type of facility being considered by the Department.

E. There Is Nothing "Skewed" Or "Unbalanced" About the Department's Methodology.

Petitioners describe the Department's methodology as "skewed" or "unbalanced." They are wrong. It is not a question of "balance." It is instead a question of policy. The Department's stated policy is to approve enough generally-available ORs to satisfy total surgical need. Petitioners' proposed alternative policy is to approve enough generally-available ORs so that the number of these ORs *combined with* limited-use "private practice" ORs will be enough to satisfy total surgical need. An

appropriate methodology to achieve the *Department's* stated goal is to exclude CN-exempt ORs from existing capacity and to include surgeries at CN-exempt ORs when determining the surgical use rate, as the Department does. An appropriate methodology to achieve *Petitioners'* stated goal would be to exclude CN-exempt ORs from existing capacity and exclude surgeries at these facilities when determining the surgical use rate.

Petitioners' argument essentially makes an unstated assumption about how many ORs should be approved, which is contrary to the Department's stated view, and then criticizes the Department's methodology because it does not lead to Petitioners' desired outcome. There is nothing "unbalanced" about the Department's approach. It is *perfectly* "balanced" if the goal is to approve enough generally-available ORs to meet the total surgical need of the public, which is what the Department has determined is the proper goal from a health planning perspective.

F. There Is Nothing "Inconsistent" In the Department's Methodology.

Petitioners also assert that the Department treats terms "inconsistently" within the regulation. Petitioners are again wrong. The "existing capacity" determination requires a calculation "of all dedicated outpatient *operating rooms* in the area" and "of the remaining inpatient

and outpatient *operating rooms* in the area[.]" WAC 246-310-270(9)(a) (emphasis added). The "future need" determination requires a projection "of inpatient and outpatient *surgeries* performed within the hospital planning area . . . based on the current number of *surgeries* adjusted for forecasted growth in the population served[.]" WAC 246-310-270(9)(b) (emphasis added). Thus, these subsections make different determinations: the existing capacity subsection counts "operating rooms"; the future need subsection projects "surgeries."

The Department treats the term "operating rooms" the same throughout the methodology. In the "existing capacity" determination, the Department counts the number of ORs excluding CN-exempt ORs. In the "future need" determination, where the regulation requires that "the capacity of dedicated outpatient *operating rooms*" be subtracted "from the forecasted number of outpatient surgeries[,]" the Department counts the capacity of outpatient ORs excluding CN-exempt ORs. In the "net need" determination, the Department "obtain[s] the area's surplus of *operating rooms*" or "the area's shortage of dedicated outpatient *operating rooms*" and will issue a CN based on the outcome of this determination. CN-exempt ORs are excluded here as well; the Program does not project "net need" for CN-exempt ORs. There is *no* inconsistency in the Department's use of the term "operating rooms" in the ASC criteria.

G. The Department's Interpretation of Its Own Regulation Is Entitled To Considerable Weight and Substantial Deference.

As explained above, the Department's interpretation of WAC 246-310-270(9) is entitled to "considerable weight" and "substantial deference." See discussion supra §IV. The Washington Supreme Court's opinion in Providence Hospital of Everett, in which the Supreme Court was reviewing the Department of Health's interpretation of another of its regulations, is illustrative. Specifically, the Supreme Court reviewed the Department's interpretation of a regulation requiring consideration of whether facilities of the type proposed "are not or will not be sufficiently available and accessible" to meet the needs of the community. Providence Hosp. of Everett, 112 Wn.2d at 358. The Department interpreted this phrase to allow consideration of a facility that had taken significant steps towards completion, but which had not yet been opened, in order to assess future need. In upholding the Department's decision, the Supreme Court stated that "substantial deference" should be given to the Department's interpretation, particularly where it involves "the agency's special knowledge and expertise." Id. at 356.

In this case, the Department's interpretation of WAC 246-310-270(9) is similarly entitled to substantial deference. How to accurately project future operating room need within health planning areas is precisely the sort of inquiry which benefits from the Department's "special

knowledge and expertise." Petitioners are effectively asking this appellate court to (1) tell the Department that it is applying an inaccurate methodology for projecting operating room need (or, at least, that it has "misinterpreted" its own methodology); (2) direct the Department to adopt a new methodology (or, at least, "reinterpret" its existing methodology); and (3) revise the State's current health care policy *de facto* by severely limiting the number of operating rooms that may be approved in the future. This is antithetical to the judicial role contemplated for a reviewing court under the APA. See RCW 34.05.574(1) (the reviewing court "shall limit its function to assuring that the agency has exercised its discretion in accordance with law, and shall not itself undertake to exercise the discretion that the legislature has placed in the agency").

Petitioners rely on Division II's opinion in Children's Hospital and Medical Center v. Washington State Department of Health, 95 Wn. App. 858, 975 P.2d 567 (1999), to suggest that this Court need not defer to the Department's interpretation of its own regulation. However, the Children's Hospital case is quite different from this one in several respects. First, Children's Hospital involved the question of what constitutes a "tertiary health service," which is a term defined partly by the Legislature, at RCW 70.38.105(4)(f), and partly by the Department of Health, at WAC 246-310-020(1)(d)(i). This case, by comparison, involves

only the Department's interpretation of its own regulation. There is *no* statute determining the need methodology for outpatient operating rooms. The Legislature left this entirely to the discretion of the Department, in the enabling legislation at RCW 70.38. An agency's interpretation of its *own* regulation is entitled to greater deference than its interpretation of a statute drafted by the Legislature. Hayes, 87 Wn.2d at 289 ("when the construction of an administrative regulation rather than a statute is in issue, deference is more clearly in order"). Therefore, this Court should give greater deference to the Department's determination in this case, which involves only the Department's own regulation, than Division II determined was appropriate in its Children's Hospital opinion, which involved a term defined partly by the Legislature and partly by the Department.

Second, and even more importantly, Division II specifically recognized, in Children's Hospital, that it *should* give "substantial weight . . . to the agency's view of the law *if it falls within the agency's expertise*[.]" Children's Hospital, 96 Wn. App. at 864 (emphasis added). However, Division II concluded that the issue in that case did not require the agency's expertise. The question in that case was whether pediatric open-heart surgery should be considered a "specialized inpatient pediatric service," which would make Tacoma General's proposed program a new

tertiary health services subject to CN review. In terms of how much Department expertise is required, a court determining whether pediatric open-heart surgery should be considered a specialized inpatient pediatric service is a far cry from a court determining how outpatient operating room need is most accurately projected within a planning area.

The issue in the Children's Hospital could be viewed as the interpretation of an unambiguous statute, which an appellate court is in a good position to do. This is certainly how Division II saw the issue. The issue in *this* case, by comparison, plainly is one that benefits from the agency's special knowledge and expertise. An appellate court is not in as good a position as the Department of Health to determine whether including or excluding surgical procedures in CN-exempt ASCs when calculating the surgical procedure use rate within a planning area results in a more accurate, or less accurate, projection of operating room need. This is precisely the type of issue that *does* benefit from the Department of Health's specialized knowledge and expertise, and therefore is the type of issue on which the Court *should* give substantial deference to the Department's determination.

Under the circumstances of this case, the Court should give considerable weight and substantial deference to the Department's interpretation of WAC 246-310-270(9).

H. The Department Would Have Acted Arbitrarily Had It *Not* Applied WAC 246-310-270(9) As It Did For Swedish.

An agency may not treat similar situations dissimilarly, and must "strive for equality of treatment." Vergeyle v. Employment Sec. Dep't, 28 Wn. App. 399, 405, 623 P.2d 736 (1981), overruled on other grounds, Davis v. Employment Sec. Dep't, 108 Wn.2d 272, 737 P.2d 1262 (1987); Seattle Area Plumbers v. Wash. State Apprenticeship and Training Council, 131 Wn. App. 862, 879, 129 P.3d 838 (2006) ("agencies may not treat similar situations in different ways."). RCW 34.05.570(h) requires the Department to rule with consistency unless there is a rational basis for inconsistency.

As previously stated, it is longstanding Department policy to include surgeries at CN-exempt ASCs when calculating the surgical use rate, but to exclude such facilities when determining total operating room capacity. AR (1st) 2023. The Department consistently applies the methodology in this fashion when evaluating ASC applications, including ASC applications for East King County. AR (2d) 504. Had the Department applied the methodology for Swedish's application as Petitioners suggest it should have, this would have been inconsistent with the Department's approach to other CN applicants, and the Department *would* have been acting arbitrarily.

I. Under the Department's Methodology, There Is "Net Need" For Additional Operating Rooms in East King County.

Under the Department's methodology, as applied, there is need for *at least* five additional outpatient ORs in East King County, and probably more, and Swedish's application was properly approved. See AR (2d) 265. Therefore, if the Court agrees with Swedish and the Department that the Department's interpretation and application of its methodology is permissible, the Court should affirm the Department's decision approving Swedish's application.

VII. CONCLUSION

The Department's interpretation and application of WAC 246-310-270(9) is consistent with the legislative intent underlying the CN statute and regulations, and is sound as a matter of public policy. It is the only approach that ensures that there are enough generally-available ORs to meet the total surgical need of the public. If the Department were to include the ORs at CN-exempt ASCs in existing capacity, it would be overstating the number of ORs available, because many of these ORs would be accessible only to individual physicians or small groups of physicians. If the Department were to exclude the surgeries at CN-exempt ASCs when calculating the number of surgeries in the planning area, it would be underestimating the number of future surgeries, because many surgeries would be excluded. Either of these revisions to the

Department's methodology, suggested by Petitioners, would undermine Washington's stated health care policy and unwisely reduce the number of new operating rooms that would be approved in the future.

If the Department ever determines that its longstanding methodology for determining outpatient OR need no longer yields accurate projections, or changes it policy view that there should be enough generally-available ORs to satisfy total surgical need, it can revise its regulation through proper rulemaking procedures. If the Legislature ever determines that the Department's approach is undesirable, it can revise the CN statute to mandate a new methodology. This Court, in contrast, should not require the Department to take a different approach to outpatient OR capacity planning. This Court should defer to the Department's interpretation and application of the outpatient OR numeric need methodology which the Department itself adopted. Swedish respectfully requests that the Court affirm the Superior Court's decision affirming the Department's approval of Swedish's application.

Respectfully submitted this 19th day of December 2007.

DORSEY & WHITNEY LLP

By: _____
Peter S. Ehrlichman, WSBA #6591
Brian W. Grimm, WSBA #29619

U.S. Bank Centre
1420 Fifth Avenue, Suite 3400
Seattle, WA 98101
Telephone: (206) 903-8800
Facsimile: (206) 903-8820

Attorneys for Respondent,
Swedish Health Services

PROOF OF SERVICE

Today I caused the foregoing BRIEF OF RESPONDENT SWEDISH HEALTH SERVICES to be served on the following persons by first class mail (with a copy also sent by e-mail):

Richard A. McCartan
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 40109
7141 Cleanwater Drive S.W.
Olympia, WA 98504

Donald W. Black
Jeffrey D. Dunbar
E. Ross Farr
OGDEN MURPHY WALLACE, PLLC
1601 Fifth Avenue, Suite 2100
Seattle, WA 98101

James S. Fitzgerald
Gregory A. McBroom
LIVENGOOD, FITZGERALD & ALSKOG, PLLC
121 Third Avenue
Kirkland, WA 98083-0908

DATED this 19th day of December 2007.

Brian W. Grimm

APPENDIX

Q But yet you testified that the 82 per 1,000 was based on counting at least some of the volume done by exempt facilities, correct?

A Yes.

Q So what is the rationale for counting the volumes in exempt facilities but not counting the facility itself?

A That's a longstanding rationale that the department has used for a number of years. The rationale behind that is that operating rooms that are approved by certificate of need or are included in community hospitals are deemed to be available to the general surgical public if they are properly credentialed to use those rooms for the treatment of their patients, whoever their patients may be.

The facilities that are described as exempt facilities, the use of those facilities is limited only to members of those group practices. And very frequently, we see that the use of these facilities is limited to one, sometimes two, different specialties of medicine, such as ENT surgery or oral surgery or something something like that. So those operating rooms are not really analogous to a generally available ambulatory surgery center, operating room, where a multitude of various services could be performed by a number of different physicians, not available to the

average patient.

Q So are you attempting to make sure that the number of surgeries can be met by the facilities that are open and generally available to everyone?

A Right. That's exactly what we're attempting to do. We have a projected number of surgeries that will occur in the future, but we don't know what they are going to be, all of a nature that would be suitable for these exempt ASCs or among patients that would be eligible for use of those ASCs. We want to insure that the general public has reasonable assurance that there will be enough operating rooms to accommodate the number of surgeries that they will need.

Q Now, you came up with the 82 per thousand based on what you did in the Northwest Nasal case. Looking at page 12 and page 13 of the record, is there a particular factor at blame in this Swedish application regarding where Swedish will be drawing patients from?

A Well, I guess I don't understand your question.

Q I'm wondering if, where would Swedish, where is Swedish saying that their patients come from?

A Oh, I understand. Well, on page 12 of the record, Swedish noted that, in 2001, one of their downtown hospitals, one of their three hospitals in Seattle, performed over 4,000 ambulatory surgery cases on

are surgeries that are presumed to be needed by the population in the future. The department is charged with, at least, facilitating access to care in such a way that we would like to see that adequate capacity is available to these patients in the future to obtain the surgeries.

So that the offshoot of that is that we count these surgeries. And we then only count a supply those rooms that are regarded as generally available. That is, as I think I have already testified, that's as I have been trained, at least, longstanding policy of the program, and that was part of my training as an analyst. That was the principal that was given to me in that way.

Q And how was that principal explained or given to you?

A I think, as muddily as I just gave you my answer, Mr. Black, and I apologize for sounding obtuse, most of my training specific to how we apply these rules has occurred on the job amid the frequent guidance of senior analysts and program management. We have frequent informal conversations on any number of issues in a given day.

When I was learning to apply this methodology, assisting my program manager on some earlier cases, this is how I was trained to apply it.

Q Is it a principal that's ever been, that you are aware